STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155791	A. BUILDING 00 B. WING	03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAIR RIDGE HEALTH CAMPUS	269 MEADOWVIEW DR PERU, IN 46970

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F0000	This visit was for the Investigation of Complaint #IN00105485. Complaint #IN00105485 Substantiated. Federal/state deficiencies related to the allegations are cited at F225, F226, F323, and F502. Survey dates: March 28-29, 2012 Facility number: 012565 Provider number: 155791 Aim number: 201021970 Survey team: Honey Kuhn, RN Census bed type: SNF: 23 SNF/NF: 5 Total: 28 Census payor type: Medicare: 14 Medicaid: 5 Other: 9 Total: 28 Sample: 5 These deficiencies reflect stated findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 4/3/12 Cathy Emswiller RN			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interviews, the facility failed to follow the facility's	F0225	1. Corrective Action accomplished for those residents found to have been affected by	04/28/2012

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	Policy and Procedure in regards to reporting to ISDH (Indiana State Department Health) and thoroughly investigating an unwitnessed fall which resulted in a fracture for 1 of 5 dependent residents who incurred a fall in a sample of 5. (Resident "F") Finding includes: The record of Resident "F" was reviewed on 03/29/12 at 12:20 p.m. Resident "F" was admitted to the facility on 03/12/12 with diagnoses including, but not limited to, history of falls, (R) (right) hip fracture, (R) wrist fracture, CRF (Chronic Renal Failure), gout, glaucoma, and dementia. During the initial tour, between 10:00 a.m. and 10:30 a.m. on 03/28/12, accompanied by the Clinical Care Coordinator (CCC-RN), Resident "F" was identified as incurring a fall at home resulting in a (R) hip & (R) wrist fracture and as being a short-term skilled resident. Resident "F" was identified as not interviewable and requiring assist of 2 staff for transfers and toileting. The CCC-RN indicated Resident "F" had an unwitnessed fall since admission to the facility. A confidential interview, during the survey, indicated Resident "F" had fallen		the alleged deficient practice: Resident F fall was submitted to the State Board of Health for review on 3-28-12. Waffle mattress was removed from bed immediately after fall. Resident F continued to have abductor pillow in place until discountinuation on 4-2-12. Bed pillow to be between knees x 2 weeks after abductor pillow discountinued. Circulatory checks started on 3-30-12. Resident F had x-ray done on 3-25-12 on hip to establish alignment. Resident F was sent to ER on 3-26-12 due to swelling of hand to have cast adjusted and evaluated.Resident F was discharge from the facility on 4-23-12.2. Indentification of other residents having potential to be affected by the same alleged practice will include:Resident's at risk for falls will be reviewed and individualized care plans will be updated to include preventions and interventions by 4-28-12.Nursing staff will be educated by 4-28-12 to review safety procedures, fall prevention, reporting of allege abuse, accidents and incidents to State and Federal entities.3. Measures put in place and systemic changes made to ensure the allege practice does not reoccur:On a ongoing basis the DHS/designees will review all incidents and accidents 5 days per week for appropriate interventions. Fall Circumstance	

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	and fractured a finger after admission. The interviewee indicated Resident "F" had relayed she had to go to the bathroom and attempted to get up by herself. The interviewee indicated Resident "F" "could not find her call light." The interviewee indicated the family was not in the facility on 03/25/12 until after the fall. Review of all records dated before 03/25/12 indicated Resident "F" had a (R) hip fracture and (R) wrist fracture, with no mention of a finger fracture. Review of the pre admission x-rays and the post fall x-rays indicated: "03/07/2012 6:55 p.m.: Findings: ...Comminuted impacted Colles' fracture...distal shaft of radius....Ulnar styloid fracture is also appreciated....Soft tissues: Unremarkable..." "03/26/2012 2:27 p.m.: Findings:...There is an acute transverse comminuted fracture of the base of the proximal phalanx of the fifth finger....There is soft tissue swelling over the dorsum of the hand..." Review of Physician's orders, dated 03/19/12, indicated: "...PT (Physical Therapy) gait training WBAT (weight bearing as tolerated) (R)		forms will be assessed for completion and root cause analysis. DHS or ED will be notified for any incident that occurs on a weekend and requires reporting to a state or federal agency.4. Corrective actions will be monitored to ensure the alleged practice does not reoccur:On a ongoing basis the DHS/designees will review new admissions and re-admissions for appropriate interventions to the residents care plan and appropriate follow up 5 days per week.QA process will be utlized for additional recommendations if indicated monthly.Compliance Date: 4-28-12	

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	LE (lower extremity).. ABD pillow (abductor pillow: a device placed and secured between the legs of a patient following hip surgery to prevent hip dislocation) @ (at) ALL times while in bed..." Review of Nurses's notes indicated: "03/24/12 1000 (10:00 a.m.) Staples removed from (R) hip s (without) difficulty....Cast D&I (dry & intact) on (R) FA (forearm). Fingers pink, warm, freely movable." The next entry indicated: "03/25/12 0930 (9:30 a.m.) Pt (patient) found on floor beside bed leaning on (R) side resting on closet door. Had been incont (incontinent) BM (bowel movement) & (and) urine. Very confused to time & place...." "03/26/12 1030 (10:30 a.m.) Called (Orthopedic Surgeon) re: (R) hand swollen & (and) cast appears to be to (sic) tight around fingers. (Orthopedic Surgeon) not in today. Suggest we send her to ER for eval (evaluation)..." Review of the "Fall Circumstance Assessment and Intervention", initiated 03/25/12, indicated: "Activity at time of fall: Transferring self...." "Environmental Inspection: Other: found			

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	"waffle mattress" on bed placed by family...." "Root cause: family placed waffle mattress on bed...." The fall investigation did not address cognitive status, if the abductor pillow was in place, when Resident "F" was last checked for toileting/incontinence prior to the fall, or the location of the call light. "03/26/12 1030 (10:30 a.m.) Called (Orthopedic Surgeon) re: (R) hand swollen & (and) cast appears to be to (sic) tight around fingers. (Orthopedic Surgeon) not in today. Suggest we send her to ER for eval (evaluation)..." The DNS (Director Nursing Services) was interviewed on 03/29/12 at 1:30 p.m. The DNS indicated the resident was in the facility for respite care only and the finger fracture was thought to have occurred prior to admission. Review of the facility Policy & Procedure: 11/2010, titled, "ACCIDENT AND INCIDENT REPORTING GUIDELINES", indicate: "Purpose: To ensure all accidents, incidents and allegation of abuse involving residents, visitors, or employees are investigated and reported to the			

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	facility administration." "Procedure: ...5. Reporting of incident, accidents and abuse to state and federal agencies shall be in compliance in accordance with agency guidelines."... 10. The administrative staff shall complete the investigation, by completion of the "Interdisciplinary Team: section of the Circumstance and Reassessment form and/or State Agency form as required." Review of the "ABUSE AND NEGLECT PROCEDURAL GUIDELINES: 11/2010", indicated, "Purpose: Trilogy Health Services,....strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect." "Procedure: ..g. Reporting i. Any staff member, resident, visitor or responsible party may report known or suspected abuse, neglect, misappropriation to local or state agencies. ii. 24 hour initial reporting to applicable state agencies.... iv. A written report of the investigation outcome, including resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days."			

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	This Federal tag relates to Complaint #IN00105485. 3.1-28(c) 3.1-28(d) 3.1-28(e)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to follow the facility's Policy and Procedure in regards to reporting to ISDH (Indiana State Department Health) and thoroughly investigating an unwitnessed fall which resulted in a fracture for 1 of 5 dependent residents who incurred a fall in a sample of 5. (Resident "F") Finding includes: The record of Resident "F" was reviewed on 03/29/12 at 12:20 p.m. Resident "F" was admitted to the facility on 03/12/12 with diagnoses including, but not limited to, history of falls, (R) (right) hip fracture, (R) wrist fracture, CRF (Chronic Renal Failure), gout, glaucoma, and dementia. During the initial tour, between 10:00 a.m. and 10:30 a.m. on 03/28/12, accompanied by the Clinical Care Coordinator (CCC-RN), Resident "F" was identified as incurring a fall at home resulting in a (R) hip & (R) wrist fracture and as being a short-term skilled resident.	F0226	1. Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:Resident F fall was submitted to the State Board of Health for review on 3-28-12.Waffle mattress was removed from bed immediately after fall.Resident F continued to have abductor pillow in place until discontinuation on 4-2-12.Bed pillow to be between knees x 2 weeks after abductor pillow discountinued.Circulatory checks started on 3-30-12.Resident F had x-ray done on 3-25-12 on hip to establish alignment.Resident F was sent to ER on 3-26-12 due to swelling of hand to have cast adjusted and evaluated.Resident F was discharged from the facility on 4-23-12.2. Identification of other residents having the potential to be affected by the same allege practice will include:Resident's at risk for falls will be reviewed and individualized care plans will be updated to include preventions and interventions by 4-28-12.Nursing staff will be educated by 4-28-12 to review safety procedures, fall prevention,	04/28/2012

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	Resident "F" was identified as not interviewable and requiring assist of 2 staff for transfers and toileting. The CCC-RN indicated Resident "F" had an unwitnessed fall since admission to the facility. A confidential interview, during the survey, indicated Resident "F" had fallen and fractured a finger after admission. The interviewee indicated Resident "F" had relayed she had to go to the bathroom and attempted to get up by herself. The interviewee indicated Resident "F" "could not find her call light." The interviewee indicated the family was not in the facility on 03/25/12 until after the fall. Review of all records dated before 03/25/12 indicated Resident "F" had a (R) hip fracture and (R) wrist fracture, with no mention of a finger fracture. Review of the pre admission x-rays and the post fall x-rays indicated: "03/07/2012 6:55 p.m.: Findings: ...Comminuted impacted Colles' fracture...distal shaft of radius....Ulnar styloid fracture is also appreciated....Soft tissues: Unremarkable..." "03/26/2012 2:27 p.m.: Findings:...There is an acute transverse comminuted		reporting of allege abuse, accidents and incidents to State and Federal entities.3. Measures put in place and systemic changes made to ensure the allege practice does not reoccur:On a ongoing basis the DHS/designees will review all incidents and accidents 5 days per week for appropriate interventions. Fall Circumstance forms will be assessed for completion and root cause analysis. DHS or ED will be notified for any incident that occurs on a weekend and requires reporting to a state or federal agency.4. Corrective actions will be monitored to ensure the alleged practice does not reoccur:On a ongoing basis the DHS/designees will review new admissions for appropriate interventions to the residents care plan and appropriate follow up 5 days per week. QA process will be utilized for additional recommendations if indicated monthly.5. Compliance Date: 4-28-12.	

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	fracture of the base of the proximal phalanx of the fifth finger....There is soft tissue swelling over the dorsum of the hand..." Review of Physician's orders, dated 03/19/12, indicated: "...PT (Physical Therapy) gait training WBAT (weight bearing as tolerated) (R) LE (lower extremity).. ABD pillow (abductor pillow: a device placed and secured between the legs of a patient following hip surgery to prevent hip dislocation) @ (at) ALL times while in bed..." Review of Nurses's notes indicated: "03/24/12 1000 (10:00 a.m.) Staples removed from (R) hip s (without) difficulty....Cast D&I (dry & intact) on (R) FA (forearm). Fingers pink, warm, freely movable." The next entry indicated: "03/25/12 0930 (9:30 a.m.) Pt (patient) found on floor beside bed leaning on (R) side resting on closet door. Had been incont (incontinent) BM (bowel movement) & (and) urine. Very confused to time & place...." "03/26/12 1030 (10:30 a.m.) Called (Orthopedic Surgeon) re: (R) hand swollen & (and) cast appears to be to (sic) tight around fingers. (Orthopedic			

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	Surgeon) not in today. Suggest we send her to ER for eval (evaluation)..." Review of the "Fall Circumstance Assessment and Intervention", initiated 03/25/12, indicated: "Activity at time of fall: Transferring self...." "Environmental Inspection: Other: found "waffle mattress" on bed placed by family...." "Root cause: family placed waffle mattress on bed...." The fall investigation did not address cognitive status, if the abductor pillow was in place, when Resident "F" was last checked for toileting/incontinence prior to the fall, or the location of the call light. "03/26/12 1030 (10:30 a.m.) Called (Orthopedic Surgeon) re: (R) hand swollen & (and) cast appears to be to (sic) tight around fingers. (Orthopedic Surgeon) not in today. Suggest we send her to ER for eval (evaluation)..." The DNS (Director Nursing Services) was interviewed on 03/29/12 at 1:30 p.m. The DNS indicated the resident was in the facility for respite care only and the finger fracture was thought to have occurred prior to admission.			

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	Review of the facility Policy & Procedure: 11/2010, titled, "ACCIDENT AND INCIDENT REPORTING GUIDELINES", indicate: "Purpose: To ensure all accidents, incidents and allegation of abuse involving residents, visitors, or employees are investigated and reported to the facility administration." "Procedure: ...5. Reporting of incident, accidents and abuse to state and federal agencies shall be in compliance in accordance with agency guidelines."... 10. The administrative staff shall complete the investigation, by completion of the "Interdisciplinary Team: section of the Circumstance and Reassessment form and/or State Agency form as required." Review of the "ABUSE AND NEGLECT PROCEDURAL GUIDELINES: 11/2010", indicated, "Purpose: Trilogy Health Services,....strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect." "Procedure: ..g. Reporting i. Any staff member, resident, visitor or responsible party may report known or suspected abuse, neglect, misappropriation to local or state			

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	agencies. ii. 24 hour initial reporting to applicable state agencies.... iv. A written report of the investigation outcome, including resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days." This Federal tag relates to Complaint #IN00105485. 3.1-28(a)			

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F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interviews, the facility failed to ensure the safety of 1 resident who incurred an unwitnessed fall resulting in a fractured finger for 1 resident reviewed for falls in a sample of 5. Findings include: The record of Resident "F" was reviewed on 03/29/12 at 12:20 p.m. Resident "F" was admitted to the facility on 03/12/12 with diagnoses including, but not limited to, history of falls, (R) (right) hip fracture, (R) wrist fracture, CRF (Chronic Renal Failure), gout, glaucoma, and dementia. During the initial tour, between 10:00 a.m. and 10:30 a.m. on 03/28/12, accompanied by the Clinical Care Coordinator (CCC-RN), Resident "F" was identified as incurring a fall at home resulting in a (R) hip & (R) wrist fracture and as being a short-term skilled resident. Resident "F" was identified as not interviewable and requiring assist of 2 staff for transfers and toileting. The	F0323	1. Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:Resident F fall was submitted to the State Board of Health for review on 3-28-12.Waffle mattress was removed from bed immediately after fall.Resident F continued to have abductor pillow in place until discontinuation on 4-2-12.Bed pillow to be between knees x 2 weeks after abductor pillow discontinued.Circulatory checks started on 3-30-12.Resident F had x-ray done on 3-25-12 on hip to establish alignment.Resident F was sent to ER on 3-26-12 due to swelling of hand to have cast adjusted and evaluated.Resident F was discharged on 4-23-12.2. Identification of other residents having the potential to be affected by the same allege practice will include:Resident's at risk for falls will be reviewed and individualized care plans will be updated to include preventions and interventions by 4-28-12.Nursing staff will be educated by 4-28-12 on call light placement.An audit tool will be developed to check 5 residents a	04/28/2012

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	155791	A. BUILDING 00 B. WING	03/29/2012

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	CCC-RN indicated Resident "F" had an unwitnessed fall since admission to the facility. A confidential interview, during the survey, indicated Resident "F" had fallen and fractured a finger after admission. The interview indicated Resident "F" had relayed she had to go to the bathroom and attempted to get up by herself. The interview indicated Resident "F" "could not find her call light." The interview indicated the family was not in the facility on 03/25/12 until after the fall. Review of all records dated before 03/25/12 indicated Resident "F" had a (R) hip fracture and (R) wrist fracture, with no mention of a finger fracture. Review of Physician's orders, dated 03/19/12, indicated: "...PT (Physical Therapy) gait training WBAT (weight bearing as tolerated) (R) LE (lower extremity).. ABD pillow (abductor pillow: a device placed and secured between the legs of a patient following hip surgery to prevent hip dislocation) @ (at) ALL times while in bed..." Review of the "Fall Circumstance Assessment and Intervention", initiated 03/25/12, indicated:		week x 1 month, then 10 residents a month x 2 months then 5 residents a month x 3 month.sQA process will be utilized for additional recommendations if indicated monthly.3. Measures put in place and systemic changes made to ensure the allege practice does not reoccur:Upon admission, the Community Service Representative (CSR) or designee will review with the resident, family and/or responsible party the importance of family and staff communication for any interventions that are added and/or removed involving the resident's plan of care and will provide examples of interventions such as mattresses, assistive walking devices etc. During the resident first (care plan) meetings, will review with the resident, familyand/or responsible party current interventions in place, new interventions added or removed, involving the resident plan of care.On a ongoing basis the DHS/designees will review all incidents and accident reports and Fall Circumstance Forms for completion, root cause analysis and appropriate interventions and add to the resident care plan and ensure appropriate follow-up 5 days per week. QA process will be utilized for additional recommendations if indicated monthly.4. Corrective actions will be monitored to ensure the alleged practice does not	

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	"Activity at time of fall: Transferring self...." "Environmental Inspection: Other: found "waffle mattress" on bed placed by family...." "Root cause: family placed waffle mattress on bed...." Review of Nurses's notes indicated: "03/24/12 1000 (10:00 a.m.) Staples removed from (R) hip s (without) difficulty....Cast D&I (dry & intact) on (R) FA (forearm). Fingers pink, warm, freely movable." The next entry indicated: "03/25/12 0930 (9:30 a.m.) Pt (patient) found on floor beside bed leaning on (R) side resting on closet door. Had been incont (incontinent) BM (bowel movement) & (and) urine. Very confused to time & place...." "03/26/12 1030 (10:30 a.m.) Called (Orthopedic Surgeon) re: (R) hand swollen & (and) cast appears to be to (sic) tight around fingers. (Orthopedic Surgeon) not in today. Suggest we send her to ER for eval (evaluation)..." Review of the pre admission x-rays and the post fall x-rays indicated: "03/07/2012 6:55 p.m.: Findings: ...Comminuted impacted Colles'		reoccur:On a ongoing basis the DHS/designees will review all incidents and accident reports and Fall Circumstance Forms for completion, root cause analysis and appropriate interventions and add to the resident care plan and ensure appropriate follow-up 5 days per week. Residents with falls will be discussed at the weekly CAR meeting x 4 weeks post fall. QA process will be utilized for additional recommendations if indicated monthly.5. Compliance Date: 4-28-12.	

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	fracture...distal shaft of radius....Ulnar styloid fracture is also appreciated....Soft tissues: Unremarkable..." "03/26/2012 2:27 p.m.: Findings:...There is an acute transverse comminuted fracture of the base of the proximal phalanx of the fifth finger....There is soft tissue swelling over the dorsum of the hand... IMPRESSION: Acute comminuted intra-articular fracture of the base of the proximal phalanx of the fifth finger...." The DNS (Director Nursing Services) was interviewed on 03/29/12 at 1:30 p.m. The DNS indicated the resident was in the facility for respite care. The DNS indicated the finger fracture probably occurred prior to admission and did not inquire further in regards to the post fall x-ray. The DNS indicated the fall was caused by Resident "F" sliding out of bed after a waffle mattress was placed on the bed by the family. The DNS indicated staff were unaware the waffle mattress was on the bed until after the fall. The DNS was queried in regards to the resident being checked for toileting throughout the night and if the staff would have been aware the waffle mattress was present at the time. The DNS was also queried if the resident's abductor pillow was in place when the resident was found			

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	on the floor. The DNS indicated the investigation did not address the resident being checked for toileting or the abduction pillow. The DNS indicated the TARs (Treatment Administration Record) would indicate if the abductor pillow was in place. Review of the TAR, dated 03/2012, for Resident "F" indicated: "03/19/12 Cont (continue) abduction pillow while in bed x 2 weeks, then D/C (discontinue) 04/02/12". The TAR addressed each shift with a signature: 6:00 a.m.-2:00 p.m.; 2:00 p.m.-10:00 p.m.; 10:00 p.m.-6:00 p.m. The TAR did not identify when the abduction pillow was put on or removed. Review of the "Nursing Admission Assessment & Data Collection" dated 03/12/12, indicated: "Mobility and ADL's (Activities of Daily Living): Transfers/Wheelchairs: Assist of 2. Assistive Device: Abductor pillow..." "Mobility and ADL Plan of Care: Transfer with assist of x 2;... Use fracture precautions per protocol...Encourage use of call light for assistance...." "Elimination:...Incontinence product use: Briefs;...Usual Voiding Pattern: Upon rising, After meals, Before bed;...Urge Incontinence: Y (yes); ...Wakes at night:			

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	Y; uses bedpan;..." "Elimination Plan of Care:..Toilet upon rising, before/after meals, before bedtime; Use toilet/bedpan,...; Use Night time brief to eliminate waking at night; Provide assistance as needed." "Safety: Has a history of falls: Y; Requires assistance to transfer: Y; Requires Assistance to ambulate: Y;...Resident is unable use call lights: forgets to use: Y..." "Safety Plan of Care: Provide assistance for transfers and ambulation as needed;...Ensure call light is within reach;...Instruct resident on use of call light." This Federal tag relates to Complaint #IN00105485. 3.1-45(a)(2)			

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F0502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview, the facility failed to ensure a physician's order for laboratory blood work was completed for 1 of 1 residents who had ordered blood work in a sample of 5. (Resident "E") Finding includes: The closed record of Resident "E" was reviewed on 03/29/12 at 9:15 a.m. Resident "E" was admitted to the facility on 03/05/12 with diagnoses including, but not limited to, COPD (Chronic Obstructive Pulmonary Disease), CHF (Congestive Heart Failure), pre-renal failure, and a history of severe dehydration. The resident was discharged home on 03/23/12. Review of the Physician's Order Sheet, dated 03/2012, indicated: "CMP (Complete Metabolic Profile), Lipid Profile, CBC (Complete Blood Count) 3/6/12" The record did not contain the ordered lab results.	F0502	1. Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:Resident #E has been discharged from the facility.Resident had order at time of admission to have a CBC, BMP and Lipd Profile obtained with no specific date attached to order to obtain specimen.Charts were reviewed on 3-29-12 to assure March labs had been completed in timely fashion.CBC was obtained on 3-9-12. Results communicated with Spouse and MD.2. Indentification of other residents having the potential to be affected by the same allege practice will include:Residents with lab orders will be reviewed Monday thru Friday in the Clincial Meeting and orders will be placed in the Lab Tracking Book, including new admission labs.Nursing staff will be inserviced on Lab Tracking form and completion and follow thru of lab orders by 4-28-12.3. Measures put in place and systemic changes made to ensure the allege practice does not reoccur:The DHS and Clinical Team will review all new admissions, re-admissions and	04/28/2012

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	Interview with the DNS (Director Nursing Services), on 03/29/12 at 10:45 a.m., indicated the labs were not drawn. The DNS indicated being unaware the tests had been ordered. Review of a Policy & Procedure, provided by the Regional Nurse on 03/29/12 at 2:30 p.m., titled, "Lab Tracking Guidelines: 11/22/08", indicated: "PURPOSE: To facilitate a method of tracking laboratory tests ordered and monitor test has been completed in a timely manner... 2. The nursing staff or person designated by the Executive Director of Director of Health Services shall monitor the 'Tracking Log" to ensure tests have been completed per the physician order." This Federal tag relates to Complaint #IN00105485. 3.1-49(a)		previous days orders for completion and follow up.4. Corrective actions will be monitored to ensure the alleged practice does not reoccur:On a ongoing basis, the DHS /designee will review new admissions, re-admissions and previous days orders for completion and follow up 5 days a week and as part of the ongoing QA process.QA process will be utilized for additional recommendations if indicated monthly.5. Compliance Date: 4-28-12.	